SECTION 8 Monitoring and 90-Day Reviews

8.1 Case Management Monitoring Standards

Case managers are to comply with all applicable DDARS standards. The following is excerpted from the draft Case Management Monitoring Standards section of the Draft Provider and Case Management Standards.

1. Case managers shall monitor and document the quality, timeliness and appropriateness of care, services and products as delivered by providers, including an assessment of the appropriateness and achievement of goals as stated in each individual's Support Plan (ISP).

2. Case managers shall be responsible for monitoring on an ongoing basis the services and outcomes established for each individual on their caseload as detailed in each individual's ISP.

3. Case managers shall initiate timely follow up of identified problems, whether self identified or referred by others. Critical issues/crisis issues shall be acted on immediately as specified in applicable DDARS, BDDS, or BQIS policies.

4. When concerns with services or outcomes are identified, case managers shall, in a timely manner, take the necessary steps to address the concerns, including, when necessary, involving the person centered planning team. Below are guidelines for how this monitoring should occur:

    a) The case manager working within their agency's internal reporting structure first contacts the provider responsible for providing the service and informs them of the concerns. The case manager and provider, using a collaborative approach, establish how the provider will address the concern and in what time frame. This initial contact should be approached by the case manager and provider as a collaborative effort to address the needs of the individual. The results of this contact should be documented in the individual's file. The collaboration should continue as the concerns are

addressed, with all professionals involved documenting the steps taken to resolve the issues.

b) The case manager will continue monitoring the services provided to ensure that the provider addresses the concern within the established time frame.

c) If the concerns are not adequately addressed the case manager should determine in his or her professional judgment whether the concerns are serious enough to negatively impact the health and safety or quality of care received by the individual. If the concerns are serious, then the next step is to contact the provider in writing, documenting the concerns that have not been addressed and requesting that providers complete a written response to how they will address the concerns and in what time frame. Copies of these letters should be forwarded to the appropriate BDDS district office. **Note – this process does not replace the BDDS incident reporting process**.

d) The case manager shall continue to monitor the situation to ensure that the concerns are resolved.

e) If the concerns are still deemed serious and are still not addressed by the provider, the case manager shall forward a letter to the provider documenting the concerns that have not been addressed, the steps that have been taken by the case manager and provider to address the concerns, and the reason the concerns still exist. Included in the letter should be dates that the case manager has monitored the situation. Copies of these letters should be forwarded to the Director of BQIS, who will review each situation and develop a plan of correction or plan of action to address the concerns.

5. A maximum response time between implementation of the support plan and the first monitoring contact shall be no more than 30 calendar days or sooner if specified in the ISP.

6. Case managers shall have face-to-face contact with each individual as determined in the ISP, with a minimum of at least one visit every ninety (90) days to assess the quality and effectiveness of the support plan. A minimum of two of these face-to-face contacts per year shall be in the home setting. It is recommended that at least one visit be unannounced.

7. Case managers shall have access to providers' quality procedures for assessment purposes.

At least every 90 days, the case manager must complete the Quarterly Review Checklist, enter the information in the INsite database and electronically transmit the information to the DDARS Waiver database.

8.2 PLAN OF CARE UPDATES AND REVISIONS

Whenever the individual needs a change in the amount or type of services, the case manager, the individual and guardian, and, as appropriate, other members of the inter-disciplinary team will cooperatively revise the POC and CCB.

The case manager is responsible for developing the updated POC and Cost Comparison following the same process indicated in the "Initial POC and CCB" section.

When an individual's health and safety are in jeopardy, the case manager and service providers must implement the POC immediately to protect the individual from harm to him/herself or others. The case manager must electronically transmit the POC and CCB to the local BDDS office within 3 calendar days, and the BDDS Service Coordinator must review the packet and electronically transmit it to the Waiver Specialist within 3 calendar days.

Except when an individual's health or safety is in jeopardy, the case manager is responsible for entering the updated POC and CCB in the INsite database and electronically transmitting it to the local BDDS office at least 14 calendar days prior to its proposed effective date. The updated POC and CCB are to reflect the updated services as well as all other Waiver services and their date ranges over the period covered by the annual POC and CCB.

The case manager and service providers may implement an updated POC and CCB prior to approval by the BDDS Service Coordinator and Waiver Specialist as long as:

a) The total cost of Waiver services for the individual do not exceed $13,500 per year and the cost of Respite Care does not exceed $2,000 per year;
b) It does not contain a service that requires a "Request for Approval to Authorize Services" form to be approved by the Waiver Specialist; and

c) There is a copy in the individual's file of the "denials" by Medicaid "prior authorization" for Occupational, Physical and/or Speech Therapy if they are being added as a new Waiver service.

Within 5 calendar days of receiving them electronically from the case manager, the BDDS Service Coordinator is to review the POC and CCB. The Service Coordinator must confirm that:

a) The identified needs of the individual will be met;
b) The health and safety of the individual will be assured; and
c) That BDDS funds to supplement the CCB are available if required.

The Service Coordinator may request additional information from the case manager to assist in reviewing the packet.

If the Service Coordinator denies the POC and CCB, a denial letter must be transmitted to the case manager. The case manager must complete a *Notice of Action HCBS Form 5* and provide a copy of the form, denial letter, the *Appeal Rights as an HCBS Waiver Services Recipient*, and explanation of the decision to the individual or guardian within 3 working days of the receipt of the denial. Other service options are to be discussed with the individual and guardian.

If the Service Coordinator approves the POC and CCB, they are to be electronically transmitted to the Waiver Specialist.

Within 7 calendar days of receiving them from the Service Coordinator, the Waiver Specialist must review the POC and CCB. The Waiver Specialist must confirm the following:

a) The individual is a current Medicaid recipient within the category of "Aged, Blind, Disabled";
b) The individual has a current ICF/MR level of care approval for the Waiver;
c) The individual continues to have an available Waiver slot;
d) The individual's identified needs will be met and health and safety will be assured;
e) The costs are consistent with the identified needs of the individual and the services to be provided;
f) That the total cost of Medicaid Waiver services for the individual does not exceed $13,500 per year and the cost of Respite Care does not exceed $2,000 per year; and
g) The individual or guardian has signed indicating acceptance of the POC and CCB, signed that they have been offered choice

of certified Waiver service providers, and signed that he/she has chosen Waiver services over services in an institution.

The Support Services Waiver Specialist may request additional information from the case manager and BDDS to assist in reviewing the packet.

If the Waiver Specialist denies the POC and CCB, a denial letter must be transmitted to the case manager and BDDS. Within 5 calendar days of receipt of the denial, the case manager must complete and provide a copy of the *Notice of Action HCBS Form 5*, denial letter, the *Appeal Rights as an HCBS Waiver Services Recipient*, and an explanation of the decision to deny to the individual or guardian. Other service options are to be discussed with the individual and guardian.

If the Waiver Specialist approves the POC and CCB, the approval letter is to be electronically transmitted to the case manager and BDDS. Within 5 calendar days of receipt of the approval letter, the case manager is to:

a) Complete and mail the *Notice of Action HCBS Form 5* and copies of the POC and CCB to the individual or guardian;
b) Mail copies of the *Notice of Action*, POC and CCB to the Waiver service providers;
c) Mail a copy of the *Notice of Action* to the local county DFC office; and
d) If necessary, update the POC information in the INsite database and electronically transmit the information to the DDARS database.

8.3 ANNUAL LEVEL OF CARE DETERMINATION

All individuals receiving Waiver services must be re-determined to meet ICF/MR level of care criteria on an annual basis.

The level of care re-determination is to be made during the same month of the year in which the initial level of care determination was made. If the individual's condition changes significantly, level of care may be re-determined prior to the annual due date.

In completing a level of care evaluation, the QMRP must obtain and review psychological, social, medical and additional records necessary to have a current and valid reflection of the individual. These records may be older than one year if the QMRP certifies that they continue to be a valid reflection of the individual. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be

obtained through the local BDDS-contracted diagnostic evaluation (D&E) team. The level of care packet must also include:

1. A completed Medicaid 450B medical form (sections 1, 2, 3, and 6) signed and dated by a physician within the past year; and
2. A Developmental Disabilities Profile (DDP) completed by the case manager within the past year. **The DDP must be done annually.**

Note: The DDP is not to be used for children under the age of five (5) years. For these children, an age-referenced comprehensive developmental assessment must be completed and utilized by the QMRP in making the level of care determination.

The QMRP must record the level of care determination in the INsite database and transmit it to the DDARS database. If the individual does not meet level of care, within five calendar days of receipt of the denial, the case manager must complete a Notice of Action form (HCBS form 5) and provide a copy of the form, the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to the individual or guardian. Other service options are also to be discussed with the individual and guardian.

The level of care determination (and, if the level of care is denied, a *Data Entry Worksheet - HCBS DE T/D)* is to be entered into the INsite database and transmitted to the DDARS database.

8.4 ANNUAL PLAN OF CARE AND COST COMPARISON BUDGET DEVELOPMENT, APPROVAL AND IMPLEMENTATION

All individuals receiving Waiver services must have new POCs and CCBs approved on an annual basis.

Annual POCs and CCBs are to cover the same months of the year as the initial ones.

The case manager must submit the *Request for Information (HCBS form 6)* to the local DFC office to obtain Medicaid eligibility information including "spend down" or "liability". The DFC office is to complete the request within 7 calendar days of receipt and return it to the case manager.

The case manager is responsible for facilitating an update to the Person Centered Plan with the individual, guardian, and anyone else the individual requests.

The case manager is responsible for developing the "annual" POC and CCB in cooperation with the individual and guardian and, as appropriate, other members of the inter-disciplinary team.

Annual POCs and CCBs are to follow the same criteria for submission, approval and implementation as described in the "POC Updates and Revisions" section. They are to be electronically transmitted to the local BDDS office at least 14 calendar days prior to the annual due date.

8.5 AUTHORIZATION OF SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES And PERS

See Section 7.10 for steps to follow when including these items in updated and annual POCs and CCBs.

8.6 TERMINATION OF WAIVER SERVICES

An individual's Waiver services will be terminated when the individual:

1. Voluntarily withdrawals;
2. Chooses institutional placement/entering Medicaid-funded long-term care facility;
3. Dies;
4. Requires services that cannot be provided in a cost effective manner by the Waiver.
5. No longer meets ICF/MR level of care criteria;
6. Is no longer eligible for Medicaid Services;
7. No longer requires Home and Community-based Services; or
8. Is no longer developmentally disabled.

When an individual terminates Waiver services, the case manager must complete a "termination" *Data Entry Worksheet (State form DE T/D*), enter the information in the INsite database, and electronically transmit the information to the BDDS and DDARS database.

The case manager must complete a *Notice of Action Form HCBS 5* and, within 5 calendar days of the termination, provide the individual or guardian with a copy of the form, the *Appeal Rights as an HCBS Waiver Services Recipient* instructions, and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

The Waiver Specialist is to provide the date and reason that the individual has terminated Waiver services to the OMPP for entry into the Indiana AIM database.

8.7 WAIVER SLOT RETENTION AFTER TERMINATION AND RE-ENTRY

If an individual who has been terminated from the Waiver wishes to return to the program, he or she may do so within the same Waiver year of his or her termination, if otherwise eligible. The individual shall return to the Waiver without going on a waiting list. "Within the same Waiver year" is considered to be from April 1 through March 31 of the next year.

An individual who has been terminated from the Waiver program within 30 calendar days may resume the Waiver with the same level of care approval date and POC and CCB if the individual's condition has not significantly changed and the POC and CCB continues to meet his or her needs. The case manager must certify that the individual continues to meet ICF/MR level of care criteria.

The case manager must complete a "Re-Entry" Data Entry Worksheet, enter it in the INsite database, and submit it electronically to the local BDDS office and the Waiver Specialist. The Waiver Specialist must provide the information to the OMPP to enter into the Indiana AIM database.

If an individual who has been terminated from the Waiver program longer than 30 calendar days wishes to return to the program and is otherwise eligible, the case manager is responsible for developing the level of care packet and POC and CCB following the same processes described in the "Annual Level of Care Determination" and the "POC Updates and Revisions" sections.

The case manager is to indicate a "Re-Entry" POC and CCB when electronically transmitting them to the local BDDS office.

When the individual re-starts Waiver services, the case manager must notify the local BDDS office and Waiver Specialist of the Waiver start date. The Waiver Specialist is to provide the level of care, start date and, if applicable, facility discharge date, to the OMPP to enter into the Indiana AIM database.

When an individual "re-enters" Waiver services:

1. If within 30 days of terminating Waiver services, the annual level of care and POC and CCB dates remain the same dates as they were prior to the termination of Waiver services,
2. If more than 30 days since terminating Waiver services, the new level of care and POC and CCB dates are used for determining when future annual level of care determinations and POCs and CCBs are due.

8.8 TRANSFER OF CLIENT INFORMATION FROM ONE CASE MANAGER TO ANOTHER

Individuals or guardians may choose a new case manager at any time. It is the responsibility of both case managers to work cooperatively with the individual to determine a transition date and assure a smooth transition of case management and Waiver services.

The "old" case manager is to provide the "new" case manager within seven calendar days of the requested transfer, the following documentation:

1. *Waiver Application for Long-Term Care Services (State form 45943*) – the most current one;
2. *Medicaid 450B* medical form – the most current one;
3. *Developmental Disabilities Profile* - the most current one;
4. Diagnostic evaluation (D&E), psychological, social, medical and other information utilized in determining the individual's most current ICF/MR level of care eligibility;
5. *Level of Care Review* form - the most current one;
6. POC and CCB - the most current one;
7. DFC Request for Information *(HCBS form 6)* - the most current one;
8. *Request for Approval to Authorize Services (HCBS form 14)* and medical doctor's prescription (if applicable) – the one(s) currently in effect, if any;
9. Client chronological notes – as needed;
10. 90-Day Review Checklists – all completed during current annual POC and CCB period; and
11. *Notice of Action (HCBS form 5)* - the most current one.

All records required to be entered in the INsite database (excluding case notes of the "old" case manager) must be current and electronically transmitted from the "old" case manager to the "new" case manager.

8.9 CASE TRANSFERS - FROM ONE WAIVER TO ANOTHER

When an individual transfers from one Waiver to another Waiver, the individual must terminate the first Waiver and be opened on the new Waiver.

The case manager shall not terminate the individual from the first Waiver until the level of care, POC and CCB, and new Waiver start date have been approved for the new Waiver.

Within five calendar days of terminating the first Waiver, the case manager must complete a "termination" *Date Entry Worksheet (form DE D/T)* and electronically transmit it to the local BDDS office and Waiver Specialist. The Waiver Specialist is to provide the information to the OMPP for entry into the Indiana AIM database.

If an individual no longer meets level of care criteria for the first Waiver but has been determined to meet level of care criteria for a second Waiver, he or she may transfer to the new Waiver if a slot is available. If no slot is available, the individual's application date for the first Waiver is to be used in determining his or her place on the waiting list for the second Waiver. These situations will be handled on a case-by-case basis.

8.10 SENATE BILL 30 CHILDREN

Senate Bill 30 (1991) is a provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under age 18 who are otherwise eligible for the Support Services Waiver.

Identification of the eligible children will be made by the Intake or Ongoing Targeted Case Manager. A *Request for Information (HCBS form 6*) will be sent to the child's local County DFC eligibility worker as an alert that the child is undergoing the evaluation process for approval of Waiver services. Upon receipt of this form, the DFC is to process the Medicaid case to the furthest extent possible without consideration of parents' income and resources pending receipt of verification of the Waiver, and then notify the case manager that the child is eligible pending approval of the Waiver.

For children who do not already have an active Medicaid case, the effective date of Medicaid and the effective date of the Waiver must be coordinated between the DFC eligibility worker and case manager.

Similarly, the effective date of a new or changed spend down under this provision must coincide with the effective date of the HCBS Waiver.

The exclusion of parental resources and income applies only as long as the child is approved for the HCBS Waiver. Parental deeming resumes beginning the month following the month in which the HCBS Waiver was discontinued for the child who continues to live with his or her parents, in accordance with timely notice requirements.